Disaster Response and Group Self-Care

Margaret Johnstone, APRN-BC

TOPIC. *This article reports on group support using Psychological First Aid during Katrina relief work. It explores this issue from personal experience and a theoretical perspective.*

PURPOSE. *Group support is useful for volunteers as well as refugees and makes it possible to deal with extraordinary events of disaster more successfully.*

CONCLUSIONS. *The use of group work with disaster and trauma survivors can have an immediate positive impact and lasting consequences in preventing post-traumatic stress disorder.*

PRACTICE IMPLICATIONS. *APRNs would benefit from group training in present centered therapy, acute debriefing, supportive, cognitive behavioral, and psychodynamic approaches. The ability to conduct groups with trauma survivors and professionals during disasters is a vital skill and service to provide immediate relief and constructive coping.*

Search terms: *Present centered therapy and disaster, psychological first aid, self-care groups and disaster, trauma groups*

Margaret Johnstone, APRN-BC, is a Mental Health Nurse Practitioner for Kaiser Permanente in Pleasanton, CA.

I experienced first hand the sustaining power of group support during my October deployment in Louisiana. I arrived in New Orleans 6 weeks after Katrina, as part of a 16-member Substance Abuse and Mental Health Services Administration (SAMSHA) mental health team. Our assignments took place in Red Cross shelters, mental health clinics, and psychiatric hospitals and on cruise ships on the Mississippi. We worked with a wide range of refugees from first responders to the chronically mentally ill. Local Louisiana mental health providers were included in our outreach. The members of my team had excellent backgrounds in mental health and many had extensive disaster response backgrounds. We had an experienced team leader who assigned our duties and was responsible for logistics. As part of our SAMSHA contract we were expected to meet, as a group, daily to discuss our assignments and process work and our emotional responses to the disaster.

Group Support for the Volunteers

My team assembled over several days as the prior SAMSHA team of workers was leaving. The stories of the prior teams experience were communicated individually as the exhausted members left for home. Most distressing were reports of group members' infighting, member exclusion, lack of leadership, and difficulty doing the assigned work. This group had not held the required daily meetings feeling they were unnecessary and too time consuming. A lack of leadership and group cohesion had been their major stumbling blocks. In spite of the hardship of working 10- to 12-hr days, we held group debriefing meetings each evening. The effort was well worth it, as my team became a well-organized team of volunteers. Our group leader focused on dealing with current problems of work logistics, transportation, and meals, along with our emotional response to our assignments. In-depth review of our response to the Katrina disaster was kept to a

minimum during our meetings although individual stressors were addressed. Group affect was kept in the midrange and assignment problem solving was a major focus of our group discussions. This was necessary due to time constraints and the need to focus on the task at hand, while still receiving group support for our emotional state.

Away from our homes, working in unfamiliar and difficult settings, the members of my mental health team established strong attachment bonds to our group and were able to provide appropriate therapy for Katrina survivors. Without this secure and supportive base to work from our daily activities would have been less effective. All of the members of my mental health team made significant contributions to the relief effort and all reported a positive experience. Many members were able to return to continue on new assignments. No member of my team reported suffering adverse mental health outcomes due to their Katrina relief work. I am happy to report that our group today continues via E-mail.

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Present-Centered Therapy for the Survivors

SAMHSA and the Red Cross recommend present-centered individual and group therapeutic intervention in the Psychological First Aid format as the intervention of choice for work with disaster survivors (SAMSHA, 2000). The goal of Psychological First Aid is to return survivors to normal functioning and reduce the incidence of post-traumatic stress disorder and depression. Psychological First Aid is offered after the initial trauma and focuses on care of the victim's physical well-being as well as connecting them to social support systems (Fetter, 2005).

Table 1. Yalom's Therapeutic Factors

1.	Instillation of hope
2.	Universality
3.	Imparting of information
4.	Altruism
5.	The corrective recapitulation of the primary family group
6.	Development of socializing techniques
7.	Imitative behavior
8.	Interpersonal learning
9.	Group cohesiveness
10.	Catharsis
11.	Existential factors

Adapted from Yalom, I. (1985). *The theory and practice of group psychotherapy* (3rd ed.). New York: Basic Book, Inc. p. 3.

Present-centered therapy is a form of supportive therapy that is problem oriented with additional social support to improve current coping. It avoids actual details of traumatic experiences although consequences of trauma are validated. For trauma groups it relies on Yalom's (1985) therapeutic (i.e., curative) factors of group psychotherapy to help strengthen members. This list of factors is described as "an intricate interplay of various guided human experiences" (p. 3) (see Table 1). Present-centered groups pay attention to current feelings, needs, and behaviors, and reorients members toward current coping (Foy, Unger, & Wattenberg, 2004). Freud (1921) reminds us that the more terrifying the external threat, the stronger the allegiance to the group becomes. This need for group affiliation is the essence of transference and significant for trauma work. Reestablishment of human attachment bonds is the goal of all trauma-related group therapies (Kaplan & Sadlock, 2003).

I was able to use present-centered therapy, in the psychological first aid format, individually and in groups for patients and families seen in my mental health clinic assignment. I found it clinically demanding

to listen to a patient's story and provide support and at the same time limiting exposure to retraumatization for vulnerable patients. Helping locate missing family members, providing food and water, filling out forms for FEMA trailers, and organizing sports for teenagers were all forms of psychological first aid we employed. The mental health team I was a part of formed a cohesive group that gave us a secure base to work from. Our recovery work would not have been as successful or rewarding without this remarkable group. The importance of having good peer support during disaster work proved to be a major asset. The use of Psychological First Aid for disaster refugees as well as for recovery workers in a group format cannot be underestimated.

Author contact: maj4u@comcast.net, with a copy to the Editor: mary@artwindows.com

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